Report on an inspection visit
to court custody facilities in

Kent

by HM Chief Inspector of Prisons

3–12 March 2022

Contents

Introduction

This report presents the findings from an inspection of court custody facilities in Kent. It covers two Crown courts and five magistrates' courts.

The Prisoner Escort and Custody Service (PECS) arm of HM Prison and Probation Service (HMPPS) had contracted Serco on behalf of HM Courts & Tribunals Service (HMCTS) to provide escort and court custody services in the region.

This was a reasonably positive inspection and there had been some good progress since our last visit in 2014. The focus of multi-agency relationships was better. Serco staff were well trained and more confident in their understanding of safeguarding. They dealt with detainees respectfully and considerately while managing risk appropriately. Some improvement to the custody estate was evident. Detainees travelled in clean, safe vehicles and were no longer routinely handcuffed, which again was positive.

Despite this progress, we do make some criticisms. For example, the range and quality of food was poor and distraction activities could have been better promoted and provided more widely. Women and children still shared transport with men and the provision for children was not always good enough. Liaison and diversion services were under-developed. The wider use of telephone interpreting services would be beneficial for those who speak little or no English. Further investment in the custody estate was required, including to enhance the facilities for detainees with disabilities.

Of greatest concern was the shortage of escort and custody staff which was pervasive. This adversely affected detainees in a number of important areas, including the length of time they spent in detention and, albeit to a lesser degree, the provision of welfare. This needed to be addressed with some urgency.

We have made 20 recommendations which we hope will assist HMCTS, PECS and Serco to deliver improved outcomes for those in their care.

Charlie Taylor
HM Chief Inspector of Prisons
March 2022

About court custody in Kent

Data supplied by HM Courts & Tribunals (HMCTS) South-east Region - Kent, Prisoner Escort and Custody Service (PECS) and Serco (custody and escort provider).

HMCTS cluster	HMCTS South-east Region - Kent
Cluster manager	Jim Doherty
Geographical area	**County of Kent**

Court custody suites	**Cell capacity**
Canterbury Crown Court	11 cells
Maidstone Crown Court	12 cells
Folkestone Magistrates' Court	8 cells
Maidstone Magistrates' Court	4 cells
Margate Magistrates' Court	10 cells
Medway Magistrates' Court	5 cells
Sevenoaks Magistrates' Court	6 cells

Annual custody throughput	
1 January to 31 December 2021	4,391 detainees
Custody and escort provider	Serco
Custody staffing	8 court custody officers 37 prisoner custody officers, including deputy court custody managers and seconded officers

Key concerns and recommendations

We last inspected court custody in Kent in 2014 and made 38 recommendations overall, seven of which were about areas of key concern (see Section 7 for a full list).

At this inspection we found that there had been good progress and 26 of the 38 recommendations had been achieved or partially achieved, including six of the recommendations about key areas of concern. Nine recommendations had not been achieved and three were no longer relevant.

Key concerns and recommendations

Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help the main agencies involved in the delivery of court custody prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

During this inspection we identified some areas of key concern and have made a small number of recommendations for HMCTS, the prisoner escort and custody service (PECS) and Serco, the escort provider.

- Key concern 1: We observed staff shortages throughout the inspection. Staff said this was not unusual and, as a result, some outcomes for detainees were adversely affected. We saw delays in delivering detainees to court in a timely way; detainees were not always moved to court quickly when requested and, on occasions, custody suites were left with too few officers to unlock detainees safely (for example to use the toilet or provide food and drinks). The common delays transporting detainees to prison/other places of detention on completion of their hearings were similarly caused by inadequate staffing. Finally, care for children was also sometimes affected by staff shortages.

  Recommendation: Sufficient, competent escort and custody staff should always be available to make sure that detainees - including children - are dealt with promptly and their needs in custody are met. (Directed to HMCTS, PECS and Serco)

- Key concern 2: Some detainees were held in court custody for longer than necessary. The reasons for this were complex and included:

  - delays in detainees being delivered to the court due to lack of staff and/or vehicles;
  - lack of cell capacity at some courts;
  - courts often starting later than expected;
  - detainees being brought to the court in the morning for cases listed in the afternoon;
  - delays moving detainees to prison once remanded or sentenced and, in some cases, locking-out to police custody;
  - delays with legal representatives receiving court papers from the Crown Prosecution Service; and

– the non-attendance of court-appointed interpreters.

Recommendation: Managers should explore and address the reasons for delays to make sure that detainees are held in custody for the shortest possible time.
(Directed to HMCTS, PECS and Serco)

- Key concern 3: Custody staff had limited understanding of the role of specialist mental health liaison and diversion services and, in many cases, did not know how to contact mental health professionals. The liaison and diversion team had a limited presence within custody, but we saw several detainees with identified mental health problems who were not coping well with detention, and who we felt would have benefited from an assessment and support from the specialist team.

  Recommendation: The role of liaison and diversion services should be better promoted and integrated into court custody arrangements. This should include substantive and regular connection with the suites and the establishment of clear and well-understood contact arrangements that custody officers can use to obtain advice and to trigger a custody visit by a designated health care professional.
  (Directed to HMCTS, PECS and Serco)

Section 1 Leadership and multi-agency relationships

Expected outcomes: There is a shared strategic focus on custody, including the care and treatment of all those detained, during escort and at the court, to ensure the well-being of detainees.

1.1 There was a clear leadership structure for court custody. Good progress had been made since our last inspection, including improved and properly focused working relationships between the three main agencies (HMCTS, PECS and Serco), particularly at a strategic level.

1.2 HMCTS and Serco have two distinct functions, respectively to deliver the judicial process and to care for detainees. The complexity and different perspectives presented continuing challenges, but these were mitigated by regular meetings at which the agencies discussed and tried to overcome issues as they arose, albeit with varying degrees of success.

1.3 The shortage of Serco staff was a significant concern that was affecting detainees adversely in a variety of ways (see key concern 1). Staff training and ongoing development activity were appropriate, and learning was well embedded in practice. Custody personnel understood the range of policies and protocols that guided their work and implemented them consistently.

1.4 A good range of data was collected and monitored. There was evidence that these data were sometimes used to address areas of improvement, for example the increased use of telephone interpreting services in some facilities.

1.5 There was a thoroughly risk-assessed approach to the management of COVID-19 in court custody but some requirements, such as cell and touchpoint cleaning, were not good enough.

1.6 Visits to court custody by independent lay observers had ceased during the pandemic and had not yet fully resumed. Their reports were appreciated by the main agencies and were used to inform plans for improvement, particularly in the condition of custody facilities.

Section 2 Transfer to court custody

Expected outcomes: Escort staff are aware of detainees' individual needs, and these needs are met during escort.

2.1 Detainees were transferred to court in clean, safe and well-equipped vehicles. Women and children still shared transport too frequently with men, especially from police stations. This was mitigated slightly by the use of partitions between the cellular compartments which afforded a degree of separation. Children were occasionally transported in cellular vehicles (see paragraph 4.24).

2.2 Most journeys to court were short and detainees alighted from vehicles quickly on arrival. Most courts benefited from a secure vehicle bay which was not overlooked. If there was no secure area for detainees to alight, efforts were made to protect detainees from view, except at Medway magistrates' court where privacy had been compromised in the past.

2.3 Most digital person escort records (dPERs, see Glossary) contained sufficient information about detainee risks, medication and property.

Recommendations

2.4 **Women and children should always be transported separately from men.**
(Directed to HMCTS, PECS and Serco)

2.5 **Detainees should be able to alight from vehicles in privacy.**
(Directed to HMCTS, PECS and Serco)

Section 3 In the custody suite: reception processes, individual needs and rights

Expected outcomes: Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

3.1 Serco staff were identified by their uniforms and name badges and were well presented. They welcomed newly arrived detainees, and detainees whom they knew were often greeted warmly, sometimes using their first names. Staff tried to establish a relationship with each detainee on arrival but some interactions were too brief.

3.2 Detainees did not have a private interview on arrival, although in some suites small notices stated that private interviews were possible. This lack of privacy might have prevented detainees from sharing sensitive information or concerns which could have helped staff to provide better care.

3.3 Staff understood that detainees were likely to be anxious and that this might affect their thinking and behaviour. Staff dealt with distressed detainees patiently and kindly in all locations. They explained court processes and structured detainees' expectations about the length of stay. We saw excellent work at Maidstone Crown Court and Folkestone Magistrates' Court, where staff showed empathy with detainees behaving in challenging ways.

Recommendation

3.4 **Staff should interview newly arrived detainees in private.** (Directed to HMCTS, PECS and Serco)

Meeting individual and diverse needs

3.5 Custody staff showed good awareness of equality and diversity issues. They spoke respectfully about detainees with a range of needs. This was a marked improvement from our previous inspection. Staff attempted to meet diverse needs where possible.

3.6 All facilities had enough female staff to meet the needs of female detainees. There was ready access to an appropriate range of menstrual care products.

3.7 Only Maidstone Crown Court custody suite was accessible for detainees with mobility difficulties. It had stair lifts, an adapted toilet and

lifts to the courts (although one was out of order). None of the suites had any other adaptations, such as a hearing loop or documents in braille. Staff were alert to non-physical disabilities and could explain how they might support people with a variety of neurodiverse needs.

3.8 Staff understood the policy for the care of transgender detainees. They used respectful language to describe how they could provide appropriate care.

3.9 A telephone interpreting service was now available in all custody suites. We saw it used well at Maidstone Crown Court, but it was not always used when required elsewhere. All courts had key documents in a range of languages, but we saw cases where detainees' rights were not provided when needed in languages other than English.

3.10 All courts had a well-stocked box of religious items which were stored respectfully. We saw evidence that these were used in most locations.

Recommendations

3.11 **Provision for detainees with disabilities should be improved.** (Directed to HMCTS, PECS and Serco)

3.12 **Detainees who do not speak good English should be interviewed using the telephone interpreting service promptly after arrival and should be routinely provided with a written copy of their rights in a language they understand.** (Directed to HMCTS, PECS and Serco)

Risk assessments

3.13 Identification and management of risk were reasonably good. Escort staff shared relevant risk information about detainees with custody staff, who checked the dPER before location in a cell.

3.14 Initial interactions with detainees were positive but often too brief. A basic reception checklist was not used consistently. Risk assessments for detainees received off-bail (see Glossary) were generally more thorough.

3.15 Staff explained that they asked additional risk-based questions if they were concerned about a detainee's vulnerability, instability or low mood. Detainees at risk of self-harm or suicide were observed more frequently, or constantly if needed.

3.16 Staff understood the level of checks required for the safety and welfare of detainees. Officers generally remained on cell corridors when detainees were present and most of the checks we observed were carried out as required. Hand-held devices for recording checks in real time were used in some but not all the courts. Poor connectivity and delays in creating individual records sometimes led to observations not being accurately recorded.

3.17 The sharing of information to make sure that all staff knew about the risks presented by or to detainees varied considerably. There were thorough verbal briefings at some courts but at others there was only a written briefing which was not always sufficiently informative or delivered promptly.

3.18 Some limited cell sharing had recently been re-introduced but cell-sharing risk assessments were not always completed when required. Detainees who were new to court custody were told how to use the cell call bells, which were answered promptly. Apart from some new recruits, all court custody and escort staff now carried personal issue anti-ligature knives.

Recommendation

3.19 **Risks associated with individual detainees should be communicated to all custody staff in a timely way.** (Directed to HMCTS, PECS and Serco)

Individual legal rights

3.20 Staff gave most detainees information about rights in custody on arrival. Staff told us that they read the rights document to detainees who needed help with reading. However, they did not always check if such help was required.

3.21 Procedures to advise legal representatives that their clients had arrived in custody were in place. There were not enough consultation rooms to meet demand at some courts and some rooms were not properly soundproofed or sufficiently private.

3.22 Detainees could not advise anyone of their whereabouts while in court custody. Such requests were usually referred to the detainee's legal representative.

3.23 There was a strategic commitment to prioritising custody cases through the HMCTS Listings Protocol (see Glossary), but this was not always achieved. A range of complex factors contributed to detainees spending longer in custody than strictly necessary, some of which had a cumulative impact (see key concern 2).

3.24 Despite liaison between custody staff and HMCTS, it was often unclear why custody cases were not always prioritised, although we acknowledged that some cases were delayed in the best interest of the detainee, for example while attempts were made to source alternative accommodation.

3.25 Some detainees' arrival at court was delayed because there were no available staff and/or vehicles to transport them. In addition, some courts lacked enough cells for the number of detainees scheduled to appear, meaning some had to travel later in the day when cells became free.

3.26 Courts did not always start promptly and some detainees arrived in the morning, even if their case was listed for the afternoon.

3.27 On conclusion of their cases, some detainees experienced lengthy waits to transfer to prison: the longest that we identified was just over six hours. Delays were again usually caused by the lack of available staff and/or vehicles. As a result, some detainees had been locked out of prison and held in a police station overnight or over a weekend because of late court sittings or failure to move detainees to prisons promptly.

3.28 Legal representatives did not always receive case files from the Crown Prosecution Service in good time, which delayed consultations with their clients.

3.29 Non-English-speaking detainees were sometimes affected by poor availability of court-appointed interpreters to assist with their cases. When interpreters failed to attend, detainees were on occasion remanded to prison, which was potentially unnecessary.

3.30 The main agencies were aware of some of these problems, but not enough was being done to understand or address the reasons for the delays and the unnecessarily extended periods in custody (see key concern 2).

3.31 Once requested by the court, detainees were produced without delay on most occasions.

Recommendation

3.32 **Interview rooms should be sufficiently soundproofed to ensure that legal consultations take place confidentially.**
(Directed to HMCTS, PECS and Serco)

Complaints

3.33 Few complaints were received. Data supplied by Serco showed that only two complaints had been submitted during 2021. Both had been responded to appropriately.

3.34 Most detainees were given information about complaints on arrival, but it was not always explained well enough. Court custody staff had a reasonable awareness of the complaints procedure but were less sure how to deal with a confidential complaint.

3.35 Contact details for the Prisons and Probation Ombudsman (PPO, the appeals body for a prisoner if dissatisfied with the outcome of a complaint) were displayed in all suites, but there was no further information about the PPO or the complaints process.

Section 4 In the custody cell, safeguarding and health care

Expected outcomes: Detainees are held in a safe and clean environment in which their safety is protected at all points during custody.

Physical environment

4.1 Conditions across the estate had improved since our previous inspection but the custody facilities needed further improvement.

4.2 Communal areas were often small and cramped with offices doubling up as kitchen areas. Cells were generally clean with little graffiti, but some looked run down and shabby with no natural light. Recently redecorated cells were better and set a standard to aspire to. We found a small number of potential ligature points in every facility, generally caused by gaps around doors or the lack of sealant around benches. We provided a separate, illustrative report of our findings.

A potential ligature point

A refurbished cell

4.3 Minor repairs were carried out quickly, but deep cleaning, painting and expensive repairs were more difficult to arrange, for example one of the lifts at Maidstone Crown Court had been out of order for several months.

4.4 Routine cleaning took place outside court operating hours but not before or after the Saturday sittings, which was unacceptable. Each court had 'touchpoint cleaning' at least twice a day to reduce the risk of COVID-19 transmission, but this was usually cursory and only in staff areas. The contractor for specialist cleaning of body fluids was responsive and effective.

4.5 The heating was not directly controlled in any of the suites. Although temperatures were taken each day, some detainees told us they were too cold or too warm.

4.6 Routes to court were safe and did not pass through public areas. Enough fixed or personal alarms were available.

4.7 Staff knew the fire evacuation plans but did not practise them with detainees regularly enough.

Recommendation

4.8 **Custody facilities should be clean, safe and well maintained.** (Directed to HMCTS, PECS and Serco)

Use of force

4.9 Most staff were up to date with their control and restraint training or had refreshers booked. Those we spoke to were properly focused on using force only as a last resort and knew of the requirement to report incidents. Staff communicated well and with a high level of tolerance, particularly with detainees who exhibited challenging behaviour. This potentially avoided the use of force in some cases.

4.10 Force had not been used against detainees in four out of seven custody suites since at least 2020. In the other three facilities, 14 incidents had been reported in 2021, although three of these involved multiple uses which should have been recorded separately, and four to date in 2022. This was not excessive. No incidents had involved children or the use of MMPR (see Glossary).

4.11 We reviewed records of all the incidents in 2021 and 2022 to date. They reflected patience and good efforts to de-escalate situations. Most only involved low-level force or restraint when detainees refused to leave the dock or board vehicles or to prevent self-harm. Individual statements were of at least an adequate standard, although a minority lacked sufficient detail about the techniques that were used.

4.12 Quality assurance of documentation was developing. Serco had some oversight of records and a PECS contract delivery manager reviewed a sample of incidents at a quarterly meeting.

4.13 Handcuffs were now only used in custody following risk assessment. Handcuffs were used in three courts to take detainees off vehicles and remained on until the detainee was outside their cell. This was unnecessary in the secure custody environment.

4.14 The teams responsible for escorting children carried waist restraint belts for use in non-cellular vehicles if necessary. We were told that they had not been used in the past year.

Detainee care

4.15 Staff cared for detainees well and responded promptly to requests. Detainees spoke favourably about their treatment in custody.

4.16 Staff offered a choice of drinks on arrival and regularly thereafter. The only food available was a range of microwave meals which met most dietary needs, but portions were small and unappetising. We considered them to be barely adequate, particularly for detainees whose trials took several days or weeks.

4.17 Toilet facilities for detainees were clean, but some were not private enough. Some had very low stable doors and at Canterbury Crown Court the urinals had no door. However, staff took care to respect detainees' privacy, standing at a suitable distance. In some courts, toilet paper and paper towels were stored unhygienically on a shelf or on the floor rather than in dispensers.

4.18 Activities to pass the time in custody were available but not always readily offered or provided. Some detainees appreciated puzzles (such as Sudoku or wordsearch). These were available in a range of languages at both Crown courts, which was good. Others preferred to read, but the range of newspapers, magazines and books was very limited. There was nothing in foreign languages and little suitable for children or those with limited literacy.

Recommendations

4.19 **The range of food available should be improved.**
(Directed to HMCTS, PECS and Serco)

4.20 **A better range of distraction activities to meet detainee need should be offered and provided more readily.**
(Directed to HMCTS, PECS and Serco)

Safeguarding

4.21 Custody staff in Kent had a better understanding of safeguarding than we have found at recent inspections. Most managers had now completed relevant training and were cascading their learning to their teams via a 'toolbox talk'. Many staff could now explain the level of concerns which should trigger the safeguarding process. The safeguarding managers were well known and their contact details readily available.

4.22 Staff told us of occasions when they had worked with the safeguarding team, Serco, to investigate potential safeguarding concerns. They described how they had liaised with relevant agencies to prevent possible harm.

Children

4.23 Children should not travel in cellular vehicles unless this is judged necessary by a risk assessment. A minority of children travelled in cellular vehicles even when this was not necessary because of staff shortages (see key concern 1). This happened most frequently when children were collected from police stations in the morning.

4.24 Staff shortages similarly prevented children from always having a dedicated enhanced care team to support them in custody. The specialist staff were not always available or only attended for part of the child's stay in custody which adversely affected the care provided. Children accompanied by an enhanced care team were usually held in a legal visits room or in an unlocked cell with the door open and could benefit from the resources that the team carried, such as board games and an electronic tablet. Children without a team were locked up and did not have access to such resources. The enhanced care officers (ECOs, see Glossary) and dual-badged officers (DBOs, see Glossary) spoke enthusiastically about their work.

4.25 During 2021, 52 children had appeared in court on 111 occasions. Data showed that some children waited several hours before appearing in court and there was little evidence of children being successfully prioritised to appear in court, although the reasons for this were unclear. Some children then had further waits before onward transfer: thirty per cent of children waited for more than an hour for a placement order.

Recommendation

4.26 **Routine care for children should be provided consistently by specially trained staff.** (Directed to HMCTS, PECS and Serco)

Health

Governance

4.27 A health needs assessment had been undertaken in 2020 by NHS England NHS Improvement as part of the PECS contract to try to make sure that health care services were appropriate to need. IPRS Aeromed delivered the physical health care support for detainees and Kent and Medway NHS and Social Care Partnership Trust were the designated liaison and diversion (L&D) team commissioned to provide support through NHS England NHS Improvement.

4.28 There was close and regular monitoring of IPRS Aeromed contract performance which was meeting the agreed specification. Staff were well trained and there were enough staff to deliver the service in a responsive way. There had only been 58 calls to the service in the last 12 months, resulting in 14 site visits across all areas. There was no evidence of any attempt within the existing governance arrangements to capture detainees' experience of health care, nor to evaluate potential gaps in meeting health need.

4.29 Clinical governance arrangements for L&D services were coherent, although it was clear that custody staff had little understanding of the role of the L&D team.

Access and care

4.30 Custody staff knew how to access general health care support and appreciated the contribution made. IPRS Aeromed offered a reliable and timely level of health care advice, initially through telephone consultation which included speaking directly to detainees if needed. There was also access to trained paramedics who could be directed to the custody suites to deliver face-to-face assessment and triage within an agreed four-hour window. This commonly occurred within two hours.

4.31 Most courts did not have direct access to L&D practitioners and few custody staff knew how to contact them for advice. They more commonly referred to a small number of Serco staff who had received enhanced awareness training. The L&D team described adopting a profile which captured need at an early point, usually at police custody

which they believed enabled support to be targeted more appropriately. However, we came across detainees who appeared to have significant mental health needs who were unknown to the L&D team and may well have benefited from specialist input (see key concern 3).

4.32 Custody staff completed First Aid training every three years. The content of the programme was good but there was little opportunity to refresh the skills learned. Despite this, all staff expressed confidence in responding effectively in the event of a medical emergency and gave examples of this. In all facilities, AEDs (automated external defibrillators) were only accessible from the main court building which could cause a delay in responding to a cardiac event in custody.

Recommendations

4.33 **All custody staff should attend an annual first aid refresher session.**
(Directed to HMCTS, PECS and Serco)

4.34 **Automated external defibrillators (AEDs) should be readily accessible in custody.**
(Directed to HMCTS, PECS and Serco)

Medicines

4.35 Most medicine handling arrangements were sound, but practices varied across the suites. Only one facility stored medicines in a locked safe as expected. Some medicines were stapled to the dPER and left insecurely in the office with other detainee documentation.

4.36 Arrangements with IPRS Aeromed enabled detainees to access most existing prescribed medication while in custody. Custody staff were confident about these arrangements.

4.37 Inconsistent information was provided by one local prison concerning detainees' medication. The dPERs were not always clear and we saw evidence of too little medication being supplied, creating unnecessary problems for detainees, custody staff and court proceedings.

4.38 Simple over-the-counter remedies such as paracetamol could not be provided by custody staff and could only be administered by calling out a paramedic. Detainees could, therefore, be in discomfort for long periods before receiving treatment. Symptomatic relief for alcohol or drug withdrawal was not provided, nor were nicotine replacement products. This represented a shortfall in the service profile and a potential risk in some circumstances.

Recommendations

4.39 **Detainees attending court from prison should be supplied with and have access to any medicines that they would ordinarily take if they were still in prison, unless there are clear contra-indications or risks associated with this. All information relating to treatment requirements and the expectations placed on**

custody staff should be clearly captured in the digital prisoner escort record (dPER). (Directed to HMCTS, PECS and Serco)

4.40 **Detainees should be able to access simple over-the-counter remedies in a timely fashion and paramedics should have more scope to support detainees experiencing signs of withdrawal from drugs or alcohol.** (Directed to HMCTS, PECS and Serco)

Section 5 Release and transfer from court custody

Expected outcomes: Detainees are released or transferred from court custody promptly and safely.

Release and transfer arrangements

5.1 Custody staff took reasonable care to make sure detainees were released safely and quickly when they had finished in court, although a pre-release checklist was not completed routinely with detainees. A private conversation took place in some courts before release, but in others there was no discussion other than to establish whether the detainee had somewhere to go and the means to get there.

5.2 Travel warrants for use on trains and petty cash for bus tickets and other sundries were available in all facilities and were readily given to detainees who needed support to get to their destination. Arrangements could be made for more vulnerable detainees to use taxis if needed.

5.3 A range of support leaflets with local information were available, with different versions for adults, women and children. These were not, however, routinely provided.

5.4 Serving prisoners who had been released by the court and who were subject to governor's authority for release (see Glossary) frequently had long waits. Data indicated that 27 of the 35 detainees released during the previous three months had waited for more than an hour. There was an escalation process but, despite this, such delays unnecessarily denied people their liberty for too long and were unacceptable.

5.5 There were frequently long delays for detainees transferring to prison on conclusion of their hearings, often as a result of staff shortages (see key concern 1). Detainees newly remanded or sentenced to prison were not routinely given information about what to expect on arrival at the establishment.

Recommendations

5.6 **Custody staff should conduct good quality pre-release risk assessments in private with detainees.**
(Directed to HMCTS, PECS and Serco)

5.7 **PECS should work closely with HMPPS and court custody providers to monitor, understand and resolve delays in releasing from court custody detainees who originated from prisons.**
(Directed to HMCTS, PECS and Serco)

Section 6 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

6.1 Key concern 1: We observed staff shortages throughout the inspection. Staff said this was not unusual and, as a result, some outcomes for detainees were adversely affected. We saw delays in delivering detainees to court in a timely way, detainees were not always moved to court quickly when requested and on occasions custody suites were left with too few officers to unlock detainees safely, for example to use the toilet or provide food and drinks. The common delays transporting detainees to prison/other places of detention on completion of their hearings were similarly caused by inadequate staffing. Finally, care for children was also sometimes affected by staff shortages.

Recommendation: Sufficient competent escort and custody staff should always be available to make sure that detainees, including children, are dealt with promptly and their needs in custody are met.
(Directed to HMCTS, PECS and Serco)

6.2 Key concern 2: Some detainees were held in court custody for longer than necessary. The reasons for this were complex and included:

- delays in detainees being delivered to the court due to lack of staff and/or vehicles;
- lack of cell capacity at some courts;
- courts often starting later than expected;
- detainees being brought to the court in the morning for cases listed in the afternoon;
- delays moving detainees to prison once remanded or sentenced and, in some cases, locking-out to police custody;
- delays with legal representatives receiving court papers from the Crown Prosecution Service; and
- the non-attendance of court-appointed interpreters.

Recommendation: Managers should explore and address the reasons for delays to make sure that detainees are held in custody for the shortest possible time.
(Directed to HMCTS, PECS and Serco)

6.3 Key concern 3: Custody staff had limited understanding of the role of specialist mental health liaison and diversion services and in many cases did not know how to contact mental health professionals. The liaison and diversion team had a limited presence within custody, but we saw several detainees with identified mental health problems who

were not coping well with detention, and who we felt would have benefited from an assessment and support from the specialist team.

Recommendation: The role of liaison and diversion services should be better promoted and integrated into court custody arrangements. This should include substantive and regular connection with the suites and the establishment of clear and well-understood contact arrangements that custody officers can use to obtain advice and to trigger a custody visit by a designated health care professional.
(Directed to HMCTS, PECS and Serco)

Recommendations

6.4 Recommendation (2.4): Women and children should always be transported separately from men. (Directed to HMCTS, PECS and Serco)

6.5 Recommendation (2.5): Detainees should be able to alight from vehicles in privacy. (Directed to: HMCTS, PECS and Serco)

6.6 Recommendation (3.4): Staff should interview newly arrived detainees in private. (Directed to HMCTS, PECS and Serco)

6.7 Recommendation (3.11): Provision for detainees with disabilities should be improved. (Directed to HMCTS, PECS and Serco)

6.8 Recommendation (3.12): Detainees who do not speak good English should be interviewed using the telephone interpreting service promptly after arrival and should be routinely provided with a written copy of their rights in a language they understand**.** (Directed to HMCTS, PECS and Serco)

6.9 Recommendation (3.19): Risks associated with individual detainees should be communicated to all custody staff in a timely way. (Directed to HMCTS, PECS and Serco)

6.10 Recommendation (3.32): Interview rooms should be sufficiently soundproofed to ensure that legal consultations take place confidentially. (Directed to HMCTS, PECS and Serco)

6.11 Recommendation (4.8): Custody facilities should be clean, safe and well maintained. (Directed to HMCTS, PECS and Serco)

6.12 Recommendation (4.19): The range of food available should be improved. (Directed to HMCTS, PECS and Serco)

6.13 Recommendation (4.20): A better range of distraction activities to meet detainee need should be offered and provided more readily. (Directed to HMCTS, PECS and Serco)

6.14 Recommendation (4.27): Routine care for children should be provided consistently by specially trained staff. (Directed to HMCTS, PECS and Serco)

6.15 Recommendation (4.34): All custody staff should attend an annual first aid refresher session. (Directed to HMCTS, PECS and Serco)

6.16 Recommendation (4.35): Automated external defibrillators (AEDs) should be readily accessible in custody. (Directed to HMCTS, PECS and Serco)

6.17 Recommendation (4.40): Detainees attending court from prison should be supplied with and have access to any medicines that they would ordinarily take if they were still in prison, unless there are clear contra-indications or risks associated with this. All information relating to treatment requirements and the expectations placed on custody staff should be clearly captured in the digital prisoner escort record (dPER). (Directed to HMCTS, PECS and Serco)

6.18 Recommendation (4.41): Detainees should be able to access simple over-the-counter remedies in a timely fashion and paramedics should have more scope to support detainees experiencing signs of withdrawal from drugs or alcohol. (Directed to HMCTS, PECS and Serco)

6.19 Recommendation (5.6): Custody staff should conduct good quality pre-release risk assessments in private with detainees. (Directed to HMCTS, PECS and Serco)

6.20 Recommendation (5.7): PECS should work closely with HMPPS and court custody providers to monitor, understand and resolve delays in releasing from court custody detainees who originated from prisons. (Directed to HMCTS, PECS and Serco)

Section 7 Progress on recommendations from the last report

The following is a list of all the recommendations made in the last report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Main recommendations

Adult men, women and young people should not be carried in the same escort vehicle and detainees should be transferred from cellular vehicles to the court cells in private. (2.18)
Not achieved

Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite. (2.19)
Partially achieved

Court custody staff should be trained to identify child protection or adult safeguarding concerns and when necessary refer vulnerable detainees to suitable agencies for support and protection. (2.20)
Achieved

A standard risk assessment pro-forma should be completed for each detainee, and staff should be trained in completing it. (2.21)
Achieved

Handcuffs should only be used if necessary, justified and proportionate. (2.22)
Achieved

There should be sufficient staff on duty at all times to ensure the safety of detainees, staff and visitors. (2.23)
Partially achieved

An immediate programme of redecoration should be put in place, with a regular programme of deep cleaning; and all graffiti should be removed. (2.24)
Partially achieved

National issues

HMCTS and Prison Escort and Custody Services should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. Standards should address detainee care and risk assessment, clarify the responsibilities of each organisation for resolving problems, and enable complaints in court custody to be monitored. Complaints should be included in the measurement of performance. (2.25)
Achieved

HMCTS should ensure that the virtual court facilities are properly monitored and evaluated so that any adverse consequences for detainees are identified and reduced. (2.26)
No longer relevant

Recommendations

Leadership, strategy and planning

There should be regular inter-agency forums covering all courts in the cluster; their remit should include improvements in the care of detainees during escort and court custody. (3.11)
Achieved

Quality assurance processes should more effectively cover key elements of detainee care and rights during escort and court custody. (3.12)
Achieved

HMCTS should ensure custody staff receive information about virtual court hearing outcomes so that staffing and other resource needs can be planned for. (3.13)
No longer relevant

Individual rights

HMCTS should liaise with the young person escort contractor to reduce delays in transferring young people to more appropriate custodial facilities. (4.14)
Not achieved

Escort vehicles should be available to take detainees to custodial establishments as soon after the completion of their court case as is practicable. (4.15)
Not achieved

HMCTS should liaise with HMP Elmley regarding its hours of operation for receiving prisoners at the weekend and its arrangements for authorising release at court. (4.16)
Not achieved

Detainees should be told about their rights on arrival at all courts, including the process for making a complaint; staff should find out if detainees can read and where they cannot, offer to read or explain the information to them. (4.17)
Partially achieved

The services of a telephone interpretation service and the means to contact it should be available to ensure detainees and court custody staff communicate effectively. (4.18)
Achieved

Complaints should be logged and there should be a process for monitoring and analysing trends. (4.19)
Achieved

Treatment and conditions

Cellular vehicles should be clean and free of graffiti. (5.17
Achieved

Custody officers should receive sufficient training to meet the diverse needs of the detainees held in court custody. (5.18)
Achieved

All court custody suites should have a copy of the holy books of the main religions, a suitable prayer mat that is respectfully stored and a reliable means of determining the direction of Mecca. (5.19)
Achieved

Designated courts that meet the needs of disabled detainees should be accessible and all court custody suites should have hearing loops as well as Braille versions of key information. (5.20)
Not achieved

GeoAmey should produce a policy, in line with police and Prison Service guidance, setting out the correct approach to caring for transgender detainees and ensure that staff implement it. (5.21)
Achieved

Staff should be briefed on how to make referrals under the local authority's safeguarding procedures if they have concerns about any young people or vulnerable detainees. (5.22)
Achieved

Young people in court custody should be supported by a named staff member trained to work with young people. (5.23)
Partially achieved

GeoAmey should liaise with HMP Elmley to improve the transfer of information and completion of detainees' PERs and ensure that property belonging to detainees travels with them to court. (5.24)
Partially achieved

All courts should have a stock of appropriate reading material, including some suitable for young people and non-English speakers. (5.25)
Not achieved

CSRAs should be completed for all detainees who are subject to them prior to any cell-sharing taking place. (5.43)
Not achieved

The outcome of cell visits should be communicated to the member of staff updating GEOtrack and records should properly reflect this. (5.44)
Achieved

Staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.45)
Partially achieved

Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody. (5.46)
Partially achieved

Each court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages. (5.47)
Partially achieved

All staff should receive annual updates in first aid training tailored for the environment to maintain an adequate skill level. (5.66)
Not achieved

First aid kits should contain sufficient up-to-date equipment, including an AED and devices for maintaining an airway and staff should be trained to use the equipment. (5.67)
Partially achieved

PERs should clearly identify the health risks for each detainee and ensure confidentiality is appropriately maintained. (5.68)
Partially achieved

All detainees who require prescribed medications while in court custody should have access to it. (5.69)
Achieved

Emergency assessments under the Mental Health Act should be available within the designated response time. (5.70)
No longer relevant

Custody staff should have regular training and clear guidance to identify, support and appropriately refer detainees who may be experiencing mental health or substance use-related problems. (5.71)
Not achieved

Appendix I About our inspections and reports

This report is part of the programme of inspections of court custody carried out by HM Inspectorate of Prisons. These inspections contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

The inspections of court custody look at leadership and multi-agency relationships; transfer to court custody; reception processes, individuals needs and legal rights; safeguarding and health care; and release and transfer from court custody. They are informed by a set of *Expectations for Court Custody*, available at http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/court-custody-expectations, about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

Four key sources of evidence are used by inspectors: observation; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Our assessments might result in one of the following:

> **Key concerns and recommendations:** identify the issues of most importance to improving outcomes for detainees and are designed to help HMCTS, the prisoner escort and custody service (PECS) and the escort provider prioritise and address the most significant weaknesses in the treatment and conditions of detainees.
>
> **Recommendations:** will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.
>
> **Examples of notable positive practice:** innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspection team

This inspection was carried out by:

Kellie Reeve	Team leader
Stephen Eley	Health care inspector
Jeanette Hall	Inspector
Fiona Shearlaw	Inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Digital Person escort record (dPER)
The PER is the key document for ensuring that information about the risk posed by detainees on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in the movement of detained people and is now in a digital format.

Dual-badged officers (DBOs)
Officers who work in custody and who additionally undertake specific training, including MMPR, to work with children.

Enhanced care officers (ECOs)
Officers who only work with and escort children. They undertake specific training, including MMPR, to provide an enhanced level of care and support. They are deployed from a central resource and remain with children throughout their stay in custody.

Governor's authority to release
The formal authorisation required to release detainees from court custody if directed by the court if they have originated from a prison. The process involves checking to ensure there are no other reasons that the detainees should be returned to prison and providing any licence conditions that are applicable to the person on release.

HMCTS Listings Protocol
The listing of cases to be heard in courts is a judicial function. There is a protocol between the judiciary and HMCTS which sets out the priorities for the listing of cases. The first priority refers to all custody cases including overnight custody cases from police stations (including arrest warrants and breach of bail cases), productions from prisons and sentencing cases.

Minimising and managing physical restraint (MMPR)
A behaviour management and restraint system, aiming to provide secure estate staff with the ability to recognise young people's behaviour, use de-escalation and diversion strategies and apply behaviour management techniques to minimise the use of restraint. See:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/456672/minimising-managing-physical-restraint.pdf

Off-bail
A person is received ‘off-bail’ into court custody directly from the courtroom when they are on bail for offences and have not been detained in custody but are subsequently remanded into custody or given a custodial sentence.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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